Hereditary Hemorrhagic Telangiectasia (HHT)

New Patient Questionnaire

DATE: ____________________________

PATIENT INFORMATION

PATIENT NAME: ____ **Date of Birth:** _____________________________

ADDRESS: ____

HOME PHONE: _________________ **WORK PHONE:** __________________ **CELL PHONE:** _________________________

Emergency CONTACT/Name_________________________**Phone**_________________**Cell Phone**__________________

MOTHER'S MAIDEN NAME: _________________________________ **SOC. SEC. NUMBER:** ___________________________

FATHER'S NAME:____ **Email Address:**

Height: ____________________ **Weight:**_______________

INSURANCE INFORMATION/PRIMARY

INSURANCE CARRIER: ___________________________________ **MEMBER ID#** ________________ **GROUP #** ________

ADDRESS: ____ **PHONE #:** _____________________

SUBSCRIBER NAME: ____

INSURANCE INFORMATION/SECONDARY

INSURANCE CARRIER: ___________________________________ **MEMBER ID#** ________________ **GROUP #** ________

ADDRESS: ____ **PHONE #:** _____________________

SUBSCRIBER NAME: ____

Who is your **REFERRING PHYSICIAN?**
Please be sure to include street address and zip code so we can mail reports.

NAME ____ **SPECIALTY** ____________________________

ADDRESS ____

PHONE ____ **FAX** ___________________________________

Who is your **PRIMARY CARE PHYSICIAN?** (The doctor who coordinates your care.)
Please be sure to include street address and zip code so we can mail reports.

NAME ________________________ **SPECIALTY** ________________________
ADDRESS ____
PHONE ________________________ **FAX** ________________________

List other specialists/MDs that care for you.
Please be sure to include street address and zip code so we can mail reports.

NAME ________________________ **SPECIALTY** ________________________
ADDRESS ____
PHONE ________________________ **FAX** ________________________

NAME ________________________ **SPECIALTY** ________________________
ADDRESS ____
PHONE ________________________ **FAX** ________________________

NAME ________________________ **SPECIALTY** ________________________
ADDRESS ____
PHONE ________________________ **FAX** ________________________

HHT FOUNDATION REFERRAL: **YES** **No**

Please explain why you are seeking medical evaluation at Johns Hopkins Hospital HHT Center:

Medical History

I have been diagnosed with the following medical conditions:

Medical Diagnosis/Condition	Date of Diagnosis	Doctor who diagnosed medical condition	Symptoms

Surgical History

I have had the following surgeries:

PROCEDURE	DATE	SURGEON	RESULT

Describe any problems you have had in the past with anesthesia or sedation:

Medications

Please list all medications you are taking, including prescription, over the counter, vitamins, supplements and alternative medications:

DRUG	DOSE	How many times per day you take medication

MEDICATION	REACTION	TREATMENT
OTHER ALLERGIES		
LATEX		
IODINE		
SEAFOOD		
CONTRAST / DYE		
FOOD		

REVIEW OF SYSTEMS - NEUROLOGIC					
Confusion		Poor balance		Blurred vision	
Difficulty Concentrating		Poor coordination		Decreased hearing	
Dizziness		Speech difficulty		Ringing in the ears	
Hallucinations		Trouble walking		Double vision	
Memory problems		Weakness- arms left/right/ or both		Fainting spells	
Personality change		Weakness- legs left/right/ or both		Trouble with smell	
Seizures		Choking		TIA/mini stroke	
Clumsiness		Difficulty chewing		Stroke	
Facial numbness / tingling		Difficulty tasting		Headaches	
Numbness– arms left/right/ or both		Drooling		Migraines	
Numbness– legs left/right/ or both		Hoarseness		**AVMs of brain Arteriovenous Malformations**	

Please provide details of any checked responses above:

EARS, NOSE, MOUTH, THROAT		CARDIOVASCULAR		GASTROINTESTINAL		HEMI-LYMPHATIC	
Balance problem		Angina		Abdominal pain		Blood disorder	
Dizziness		Chest pain		Constipation		Diabetes	
Ringing in ears		Chest pressure		Diarrhea		Endocrine disorder	
Hearing loss		Fainting		Gastritis		Diabetes Type I or Type II	
Trouble breathing through nose		Heart Failure		Hepatitis		Sickle Cell Disease	
Nose bleeds / discharge		Heart Murmur		Hiatal hernia		Thyroid Disease	
Sinus disease		High blood pressure		Rectal bleeding		Enlarged lymph nodes	
Mouth sores		Low blood pressure		Ulcer		HIV exposure	
Sore throat		Shortness of breath		Vomiting		AIDS	
Trouble swallowing		Leg swelling		Polyps		Von Willabrands	
AVMs/telangiectasia of nose Arteriovenous Malformations		Hole in Heart		Loss of Bowel Control		Hepatitis	
		Pacmaker		Blood in Stool		Infectious Disease	
		Defibrillator		**AVMs of GI tract Arteriovenous Malformations**			
				AVMs of liver Arteriovenous Malformations			

Please provide details of any checked responses above:

CONSTITUTIONAL		RESPIRATORY		MUSCULOSKELETAL		EYES	
Altered taste/smell		Bronchitis		Low back pain		Blurred vision	
Change in appetite		Emphysema		Neck pain		Double vision	
Weight loss or gain		Pneumonia		Joint pain		Glaucoma	
Unable to sleep		Tuberculosis		Joint swelling		Cataracts	
Excessive sleepiness		Chronic cough		**AVMs of spine Arteriovenous Malformations**			
Fatigue		**AVMs of lungs Arteriovenous Malformations**					
Fever							

Please provide details of any checked responses above:

INTEGUMENTARY		PSYCHIATRIC		URINARY	
Breast disease		Anxiety		Increased frequency	
Skin rash		Depression		Loss of bladder control	
Port wine stain		Trouble concentrating		Blood in urine	
AVMs of Skin/ Telangiectasia		Alcoholism		Kidney stones	
		Drug Abuse		Sexual dysfunction	
		Tobacco/cigarettes			
		Tobacco/chew			

Please provide details of any checked responses above:

SCHOOLING / EDUCATION
HIGH SCHOOL/Degree:
College/Degree:
Occupation/Job:
Exposure to Environmental Hazards **Industry** **Chemicals** **Radiation** **Other**

Please provide details of any environmental exposures:

Please Check which best describes your activity level:

I	No symptoms and no limitation in ordinary physical activity
II	Mild symptoms and slight limitation during ordinary activity
III	Marked limitation in activity due to symptoms, even during less -than -ordinary activity
IV	Severe limitations. Experiences symptoms even at rest

MRI/CT Screening questions:

1. **Do you have any metal in your body?**____
2. **Are you allergic to contrast/dye used during imaging (MRI/CT)?**__________________________
3. **Do you have diabetes, kidney or liver problems?**__________________________________

Family History

Mother	**Age**	**Health Problems**	**Cause of Death**
Father			
Your Aunt s (mother's sisters)			
Your Uncles(mother's brothers)			
Your Aunts(father's sisters)			
Your Uncles(father's brothers)			
Grandparents(your mother's parents)			
Grandparents(your father's parents)			
Your Brothers			
Your Sisters			
Your children			

Your children			
Your children			
Your children			
Spouse/Significant other			

Please provide any additional information that we may need to know about you:

Diagnostic Test/Records	Have you had this test?
Chest X-Ray	DATE
Brain-MRI with Contrast	DATE
Lungs-3 D CTA Cat Scan	DATE
Liver-3 D CTA Cat Scan	DATE
Blood Test- CBC w Differential	DATE
Blood Test- Comprehensive Metabolic Panel	DATE
Blood Test- PT/PTT	DATE
Agitated Saline/Bubble Echo	DATE
GI-Endoscopy	DATE
GI-Capsule Endoscopy	DATE
GI-Augmented Small Bowel Enteroscopy	DATE
GI-Colonoscopy	DATE
Genetic Testing	DATE
Other	DATE
Other	DATE
Complete New Patient Questionnaire	DATE
Insurance Card-Copy Front and Back	DATE
Request medical Records 1. Problem list 2. Recent Physical 3. Recent lab tests 4. Hospital Adm/Surg 5. Medications/Allergies *less than 20 pages please	DATE

The following must be received prior to scheduling an appointment: 1. **New Patient Questionnaire** 2. **Copies with reports of any imaging pertaining to HHT (brain MRI, chest CT, liver CT)** **DO NOT SEND ORIGINALS** 3. **Medical Records** 4. **Copies of insurance card, front and back**	**Send to:** **Gina M. Robinson, RN HHT Program Coordinator** **The Johns Hopkins Hospital** **Interventional Radiology Center** **Bloomberg 3287** **1800 Orleans Street** **Baltimore, MD. 21287** **Fax 410-955-0233** ***Copies and reports of imaging (brain MRI, chest CT, liver CT) need to be FED EXPRESSED to above office. DO NOT SEND ORGINALS.** ***DICOM Format for all images-CT and MRI** **Copies and reports of imaging will not be returned.**

Thank you for completing the new patient questionnaire. If you need assistance completing this form or have questions, please call Gina Robinson, RN @ 410-502-3628.